

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155751		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2015	
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00170820, IN00171179, IN00171666, IN00171881.</p> <p>Complaint IN00170820 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00171179 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00171666 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00171881 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: April 26, 27, 28, 2015</p> <p>Facility number: 0004831 Provider number: 155751 AIM number: 200809750</p> <p>Census bed type: SNF: 21 SNF/NF:109 Residential: 54 Total: 184</p> <p>Census payor type: Medicare: 25 Medicaid: 73 Other: 32 Total: 130</p> <p>Sample: 06</p> <p>Meadow Lakes was found to be in compliance</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155751	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/28/2015
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1 in regards to the Investigation of Complaints IN00170820, IN00171179, IN00171666, IN00171881. .	F 000			